ARMY NURSE CORPS NEWSLETTER

"Ready, Caring, and Proud"

Volume 02 Issue 03 *December 2001*

Message from the Chief

November afforded me the opportunity to speak at two events that reinforced my belief in the high quality, energy and enthusiasm of those individuals entering, or about to enter, our great profession of Nursing. Over one thousand student nurses gathered in early November at the National Student Nurses Association mid-year conference in Reno, Nevada. It was extremely refreshing to have the opportunity to interact with these highly motivated young professionals, many of whom will go on to be our Nursing leaders of tomorrow. We discussed the many rewards of pursuing a career in Nursing, the multitude of professional opportunities within Nursing and the challenges that currently exist within our profession. We also discussed society's demand for quality health care, increased access to health care and its potential impact on the requirement for Registered Nurses to be even greater in the foreseeable future. We also talked about the importance of staying actively involved in professional organizations, for it is by their dedicated participation and commitment to forming change to benefit our profession that will advance our Nursing agenda.

The second event I had the opportunity to speak at was the Officers Basic Course graduation on 16 November. This also was an energized group of young professionals; 124 of the 310 new officers being Army Nurse Corps Officers. It is also refreshing to me to see the enthusiasm, excitement and readiness of these outstanding young officers to get to their first assignment and begin the journey down the road of professional Nursing. I encouraged them to be cognizant of the great history of our Army Medical Department and the many contributions of those that have gone before them. I also encouraged them to work hard at maintaining the great reputation we have developed over the years and never loose sight of our purpose - - - quality care to our soldiers, their families and our retired population.

As 2001 comes to a close, I want to take this opportunity to wish each of you a most joyous, safe and happy holiday season. I extend this wish to all members of the Army Nurse Corps family – our enlisted soldiers, NCO's, officers, and civilians, both active and reserve component. It is especially important during this time of year that we remember those who will not be spending the holidays with their loved ones. We should keep those who are serving in far away places in our thoughts and prayers. We in the Army Nurse Corps will continue to play vital roles as our nation responds in force to the senseless terrorist acts of September 11th. I know we will be ready to successfully respond to any mission(s) we are asked to support and, as we have done for the past one hundred years, do it with the professionalism and compassion that we are so well noted for displaying. Thank you for all that you do and best wishes for a happy and safe holiday season.

Army Nurses are Ready, Caring, and Proud!

Bill Bester
Brigadier General
Chief, Army Nurse Corps

Office of the Chief, Army Nurse Corps

Fort Sam Houston Office
COL Deborah Gustke
LTC Ellen Forster
CPT (P) Laura Feider
Office of the Army Nurse Corps
AMEDD Center and School, CDR
ATTN: MCCS-CN, ROOM - 275
2250 Stanley Road
Fort Sam Houston, Texas 78234
210-221-6221/6659
DSN 471
Fax: 210-221-8360
ellen.forster@cen.amedd.army.mil
(substitute name for all others)

Washington D.C. Office
LTC (P) Margaret Bates
Headquarters, DA
Office of the Surgeon General
6011 5th Street, Suite #1
Fort Belvoir, VA 22060-5596
703-806-3027
DSN 656
Fax: 703-806-3999
margaret_bates@belvoir.army.mil

AN Web Site:
www.armymedicine.army.mil/otsg/nurse/index.htm

ANC Branch PERSCOM:
www.perscom.army.mil/ophsdan/default.htm

Giclée Painting by Richard J. Rezac

Article Submissions for the ANC Newsletter

The ANC Newsletter is published monthly to convey information and items of interest to all nurse corps officers. If you have an item that you feel would be of interest to your fellow ANCs, please e-mail to CPT Feider. The deadline for all submissions is the last week of the month prior to the month you want the item published. We reserve the right to edit and review any item submitted for publication. All officers are eligible to submit items for publication.

PERSCOM UPDATE

Army Nurse Corps Branch Web Page
The direct address for our web page is: www.perscom.army.mil/ophsdan/default.htm. Please visit our site to learn more about AN Branch and for matters pertaining to your military career.

Upcoming Boards

05-14 Dec 01	COL AMEDD Command
05 Feb 02	BG AMEDD
12-22 Feb 02	LTC AMEDD
05-15 Mar 02	CPT AMEDD & VI
04-21 Jun 02	Senior Service College
09-19 Jul 02	COL AMEDD & RA Selection
09-26 Jul 02	Command & General Staff College

See PERSCOM Online (www.perscom.army.mil) for MILPER messages and more board information. To access the messages, go to PERSCOM Online, double click "Hot Topics", then select MILPER Messages.

FY02 Brigadier General AMEDD: 05 February 2002 (Milper Message #02-024)
Zone of Consideration: COL date of rank 01 Feb 01 and earlier

OERs due to OER Branch, PERSCOM: NLT 29 January 02 Promotion Reports (Code 11) do not apply to GO selection boards. Required "Thru Date" for Code 21 Complete the Record OERs: 30 Nov 01. Letters to the President of the Board: due NLT 05 February 2002. Request for microfiche: e-mail: offrcds@hoffman.army.mil or fax: DSN 221-5204 / 703-325-5204. Send DA Photos and signed Board ORB to CPT Gahol NLT 22 January 2002. POC is CPT Bob Gahol, AN Branch, PERSCOM, DSN 221-8124 / 703-325-8124 or gaholp@hoffman.army.mil

FY02 Lieutenant Colonel AMEDD: 12-22 February 2002 (Milper Message #02-010)
Zones of Consideration:

	MAJ date of rank
Above the Zone	31 Jan 96 and earlier
Primary Zone	01 Feb 96 thru 30 Jun 97
Below the Zone	01 Jul 97 thru 01 Sep 98

OERs due to OER Branch, PERSCOM: NLT 05 February 02 Required "Thru Date" for Promotion Reports (Code 11) is 07 December 01. Required "Thru Date" for Code 21 Complete the Record OERs: 07 December 02 (BZ eligible officers are not eligible for "Complete the Record" OER). Letters to the President of the Board: due NLT 12 February 2002. Request for microfiche: e-mail: offrcds@hoffman.army.mil or fax: DSN 221-5204 / 703-325-5204.. Send DA Photos and signed Board ORB to CPT Gahol NLT 22 January 2002. POC is CPT Bob Gahol, AN Branch, PERSCOM, DSN 221-8124 / 703-325-8124 or gaholp@hoffman.army.mil.

FY02 CPT AMEDD: 5-15 March 2002 (Milper Message not yet available). Officers must have 12 months or more AFCS before the board convene date to be eligible for this board.

	1LT date of rank
Above the Zone	31 Mar 00 and earlier
Primary Zone	01 Apr 00 thru 31 Mar 01

LTHET
Officers selected to attend (FY02) LTHET must complete Phase 2 of the OAC prior to the start of school. **OAC dates have been revised:**

6 January - 12 March 2002
24 March - 24 May 2002

LTHET Report Dates:

Program	Report Date	Start Date
Baylor (HCA)	1 June 2002	11 June 2002
USUHS (CRNA & FNP)	29 May 2002	10 June 2002
U.S. Army (CRNA) Program	7 June 2002	17 June 2002

OCONUS officers will be given a report date 14 days prior to the start of school if the losing command can support the action.

Officers scheduled to attend the AMEDD Officer Advanced Course en-route to the U.S. Anesthesia Nursing and Baylor, HCA Programs will report 12 March 2002 as a PCS move. These officers are not entitled to TDY funding to attend the Officer Advanced Course, since they will remain at Fort Sam Houston. Permissive TDY and/or leave are approved by the losing command.

Request For Orders (RFOs) have been generated for those officers scheduled to attend Baylor, HCA; FNP, USUHS; Anesthesia Nursing, USUHS; and the U.S. Army Anesthesia Nursing Program. Contact your local PSB for orders.

Transcript Updates
Officers should have transcripts mailed directly to AN Branch:

COMMANDER, PERSCOM
TAPC-OPH-AN, (Attn: MAJ Lang)
200 Stovall Street, Rm 9N47
Alexandria, VA 22332-0417

Short Courses
To find out the updated class schedule, please visit the Army Nurse Corps branch web site at http://www.perscom.army.mil/ophsdan/profdevt.htm

To find the latest course schedules for military short courses check the following web sites:

C4 and C4A: www.dmrti.army.mil
Chemical Casualty Course: www.ccc.apgea.army.mil
HNLDC & ANLDC:
www.dns.amedd.army.mil/ANPD/index.htm

Preparation for TDY Courses
Just a friendly reminder, it is the responsibility of each unit to ensure that all officers going TDY are able to meet the Army's height/weight and APFT standards. For any course that generates an AER, officers must be able to pass these standards to pass the course.

Officer Advanced Course
MAJ Lang at AN Branch schedules officers for Phase II of OAC once the officer has completed Phase I. OAC class dates for FY 02 are located at http://www.perscom.army.mil/ophsdan/profdevt.htm.

CGSC and CAS3 through the Reserves
Taking **CGSC** and **CAS3** through the **Reserves** has become very popular and classes do fill quickly at the more popular locations and times. Please plan early. Send your completed 3838s, signed by your respective chain of command, and fax to **LTC Jane Newman** at **DSN 221-2392**, com. **703-325-2392 (newmanj@hoffman.army.mil)**. The web address is WWW-CGSC.army.mil. If you have ATRRS CGSC & CAS3 related questions, the contact is Ms Jennifer West **DSN 221-3159.**

Information for the Reserve Component (RC) CAS3 can be found on line. The information pertains to AD officers attending Reserve Component CAS3. Points of contact for specific reserve component regions are listed. Please do not attempt to register on-line. Registration for CAS3 and CGSC must be processed through your respective local training chain of command. LTC Newman is the AN Branch POC. Ms Jennifer West (DSN 221-3161) is an additional POC for specific questions.

If you are currently enrolled in another service's CGSC or are contemplating signing up for another service's CGSC, please contact your PMO to discuss your plan.

Generic Course Guarantee
As you may know, the Generic Course Guarantee is a wonderful program offered to junior officers (those who qualify when they access to active duty) to receive specialized training in the Critical Care, Psychiatric-Mental Health, OB-GYN or Perioperative Nursing course while on their initial tour of duty (first 3-4 years on active duty). While it is very much encouraged for junior officers to take advantage of this super opportunity and attend one of the courses, there may be a misperception among some who have the Generic Course Guarantee, that in order to remain competitive for promotion and career progression, they MUST accept the Generic Course Guarantee and attend one of the above listed courses. This is a misperception! Please keep in mind, the elements that make an officer's record competitive: good performance, meeting AR 600-9 standards, passing APFT, meeting career gates (i.e. AOC, CGSC, LTHET etc), diversity of positions (TDA, TO&E, clinical, staff etc). If you have any questions or concerns regarding the Generic Course Guarantee, please speak with your nursing chain of command (head nurse, section supervisor, chief nurse etc) or hospital education POC or contact LTC Hough, AN Branch at **houghc@hoffman.army.mil**.
Specification of a generic course guarantee must take place within a year of the officer coming on active duty (time starts when officer reports to active duty). Officers who enter active duty with no prior nursing experience, must have a minimum of **one-year nursing** experience before attending an AOC producing course. Officers, who have prior nursing experience, must have at **least six months** Army nursing experience before specifying a course and must have at least one year remaining on active duty at the completion of the course. Again, the courses available for attendance through the Generic Course Guarantee program are Critical Care, Psychiatric-Mental Health, OB-GYN, and Perioperative Nursing Course. Officers who desire to attend the Emergency Nursing course (M5) or Community Health Nursing course must decline their Generic Course Guarantee.

AOC/ASI Producing Courses POCs
Critical Care Course, Emergency Nursing Course, Psychiatric-Mental Health and OB-GYN Nursing Course Manager: LTC Hough at houghc@hoffman.army.mil

Perioperative Nursing Course Manager: LTC Newman at newmanj@hoffman.army.mil.

Community Health Nursing: LTC Ross at rossa@hoffman.army.mil

There are still seats available in the following courses:
--JAN 02 Critical Care Course at MAMC
--JAN 02 Psychiatric-Mental Health Course at WRAMC
--FEB 02 OB-GYN Nursing Course at TAMC

Please see your facility's Nursing Education Representative or nursing chain of command if you are interested in attending. Please note FY02 AOC/ASI Course dates are listed at http://www.perscom.army.mil/ophsdan/profdevt.htm.

66F/66E Assignment Opportunities
Assignment opportunities are available for 66Fs at FT. Bragg, Ft. Campbell, Ft. Gordon, Ft. Hood, Ft. Leonardwood, Ft. Leavenworth, Ft. Polk, Ft. Riley, Ft. Stewart, Tripler, WRAMC, Europe and Korea, summer 2002. Assignment opportunities for 66Es include Ft. Sill, Tripler, Europe and Korea. For these and other opportunities please inquire to LTC Newman, **newmanj@hoffman.army.mil**.

Assignment Opportunities for 66H Lieutenants
Invest in AMERICA!!! TO&E assignments available for motivated 66H LT's at Ft. Hood, Ft. Bragg, Ft. Campbell, Ft. Carson for spring/summer 02. Being TO&E assigned is a wonderful opportunity to experience a different kind of nursing, enjoy career diversity (not to mention TO&E assignments are career enhancing and can make records more competitive) and travel. If interested, please contact LTC Charly Hough, PMO for 66H LT's and new accessions, email **houghc@hoffman.army.mil**

Assignment Opportunities for Captains
Officers commissioned under the Army Enlisted Commissioning Program (AECP) 1990-1994 please take a

moment to check your mandatory retirement date with your local personnel office. Although AECP officers during this time frame may have received a waiver in order to attain 10 years Active Federal Commissioned Service (AFCS), it still may not be reflected in the system. If this is not corrected, the officer may be dropped from the system; this almost happened to an officer last month. If the date is incorrect, please email/call MAJ Krapohl and I will walk down to the Retirements and Separations Branch to have it changed. This does not apply to officers that are already selected for RA.

Summer assignments are underway. Assignment opportunities are on the website. If interested in any of the assignments please notify your Chief Nurse and contact MAJ Greta Krapohl at krapohlg@hoffman.army.mil

AN BRANCH PERSONNEL E-MAIL ADDRESSES

Please note that our e-mail addresses are not linked with the MEDCOM e-mail address list. We continue to receive numerous calls from the field about "undeliverable" messages when you try to send us e-mail messages. Our e-mail addresses are as follows:

COL Feeney-Jones	MAJ Krapohl
feeneys@hoffman.army.mil	krapohlg@hoffman.army.mil
LTC Haga-Hogston	MAJ Lang
hagas@hoffman.army.mil	langg@hoffman.army.mil
LTC Newman	CPT Gahol
newmanj@hoffman.army.mil	gaholp@hoffman.army.mil
LTC Hough	Ms. Bolton
houghc@hoffman.army.mil	boltonv@hoffman.army.mil
LTC Ross	Mr. Shell
rossa@hoffman.army.mil	shellj@hoffman.army.mil

SMART TIPS FROM THE FUTURE READINESS OFFICER

By CPT Bob Gahol

Understanding OERs

We all know that one of the most critical items that the board members look for during selection boards are the officer's Officer Evaluation Reports (OERs). OERs provide performance information to selection boards and assignment managers. OERs can also be a powerful tool to use towards leader development, inculcation of values and leadership doctrine, and counseling the transition of the new officers into the Army culture.

When we conduct our board scrubs, we thoroughly review each individual officer's OERs. We look at the duty title/duty description, most recent APFT, Ht/Wt report, and carefully read what the rater, intermediate rater and senior rater has to say about the officer. Every section of the OER is carefully evaluated, and we annotate for any pattern of performance/behavior. Many times, we can predict if the officer has a good chance of getting selected or not based on our thorough review of the officer's evaluation reports. Every officer must be knowledgeable in every aspect of the OERs. A simple mistake can create a lasting effect in the officer's career. Below is an article written by the OER Branch on some of the most common mistakes they find in OERs. I recommend visiting the website: http://www.perscom.army.mil/tagd/oers/oers.htm for more information.

While the Army changed the OER form in 1997, it did not change the basic requirements and standards used in preparing OERs. While the majority of people in rating chains understand this principle, some individuals appear to have assumed that a new OER system meant all standards changed. OER Branch has been receiving an increasing number of poor quality OERs. Often, they are copies, sometimes printed on two separate pages, frequently not "head-to-foot", and containing many errors. ***Narrative gimmicks, such as double-spacing, BOLD type, exaggerated margins or "picture-framing," etc. is not allowed.*** All OERs must be signed and dated by all members of the rating chain and the rated officer. These rules have not changed and they were the same rules required for preparing 67-8 OERs. Other frequently recurring errors that continue to delay processing are highlighted below for your attention.

1. PART V.c.

This is the most misunderstood portion of the DA 67-9. The bulk of OER errors (a conservative 75 percent or more) occur in this portion of the report. While the instructions are clear, somehow many people misinterpret or disregard the stated instructions. The only entries a rater should make in this block are:

- Identification of a **unique skill(s)** that the rated officer possesses which is deemed pertinent by the rater and
- a **career field recommendation** for Army Competitive Category Captains through Lieutenant Colonels.

Most errors occur because the rater goes beyond what is requested and recommends projected assignments tied to the unique skill or adds comments on the officer's future potential. All recommendations for future assignment, schooling, promotion and/or command are considered potential comments and should be made in Part V.b. (the rater's narrative covers both the officer's performance during the rating period and his/her potential). When preparing an OER, restrict yourself to what is asked for (i.e., identify any unique skill the officer possesses. No comment required if there is no unique skill) and recommend the career field for all Captains through Lieutenant Colonels [with the branch or functional area] for which you think an officer is best suited.

Facts to remember about career field recommendations:
1. Career field recommendations apply to Army Competitive Category officers only. Special branches should not have career field recommendations nor should Warrant Officers, Lieutenants, or Colonels.
2. Both the rater and senior rater must make a career field recommendation. However, each rating official can only recommend one career field. OERs with more than one recommendation require correction before the OER can be

accepted. This causes unnecessary delay in processing the OER. Too frequently, OERs submitted for selection boards are delayed while OER Branch attempts to contact rating chain officials to correct reports before they can be sent to the board. Non-Board OERs may end up being returned for correction of this error because time constraints and high volume workload do not permit the extensive coordination often required. Refer to the MILPER message (MILPER MSG #98-194) which outlines clearly how to address career field recommendations.

2. LACK OF POTENTIAL COMMENTS (PART V.b.)

Another major error occurring in Part V.b. (the Rater's narrative) is ***the lack of comments on the rated officer's potential (promotion, command, future assignment and schooling recommendations).*** Such comments are mandatory (see AR 623-105, paragraph 3-20.b.(2)). Even though the senior rater focuses on potential in his portion of the OER (Part VII.c.), the regulation also requires the rater to address potential. Overall OER processing time could be reduced significantly if all raters ensured they included comments on the rated officer's potential in Part V.b. ***Again, remember that Part V.b. is the place for potential comments not Part V.c.***

3. LACK OF 3 FUTURE ASSIGNMENTS RECOMMENDATION (PART VII.d.)

The next most frequent error is the lack of a senior rater's recommendation for three future assignments for the officer being rated. This is due in part to a misinterpretation of instructions concerning Part VII.d. There are two sentences to the instructions for block VII.d.: (1) "List 3 future assignments for which this officer is best suited." and (2) "For Army Competitive Category CPT thru LTC, also indicate a potential career field for future service." Many senior raters or their staffs read the first line, not the first sentence, and assume they are required to list three future assignments only for Captains thru Lieutenant colonels. THAT IS INCORRECT. ***Senior raters are required to list three future assignments for all officers (including general officers)*** (See AR 623-105, paragraph 3-22, c.(4)). Even in cases of adverse OERs, these recommendations are required and are valuable to determine a suitable assignment for the rated officer while awaiting any administrative action that may be pending.

4. COMPLETION OF PART IV.a and PART IV.b.

The main problem with Part IV of the OER is incomplete required information. Raters need to ensure all portions of this section are complete. Answer all yes/no questions first. Part IV.a. requires seven Yes/No answers. Part IV.b. requires 16 Yes/No answers, plus, a designated number of selections that provide the rater's assessment of the rated officer. Once you complete those answers, go back and select the required number of Attributes/ Skills/ Actions required. In Part IV.b.1., the rater is required to select one Attribute which best describes the rated officer's strength; in Part IV.b.2., the rater must select two Skills; and in Part IV.b.3., the rater must select three Actions. If you have questions on Part IV, refer to AR 623-105, paragraph 3-19 for additional guidance.

5. COMPLETION OF PART IV.d.

Initially, there was confusion with regard to Part IV.d. The question asked refers to the rated officer not the rater. The easiest way to look at this question is to ask yourself: Does the rated officer rate any LTs or WO1s? If the rated officer does not rate any LTs or WO1s, you should mark "NA" (not applicable). If the rated officer does rate LTs or WO1s, ask yourself, did the rated officer comply with the requirements of the Junior Officer Developmental Support Form (DA Form 67-9-1a) regarding the LTs/WO1s he rates? If the answer is yes, mark the "Yes" block. If the "No" block is marked, it indicates the rated officer did not do his job and the rater is required to comment on the negative response in Part V.b. (rater's narrative). DA Pam 623-105 helps clarify this issue. Also, you may refer to MILPER MSG # 99-113 dated 23 Mar 99, Subject: New Officer Evaluation Reporting System Counseling Requirements. While there are still mistakes in this area of the OER, things are improving.

6. SENIOR RATER NOT SENIOR ENOUGH

OER Branch still receives a significant number of OERs with invalid senior raters. The most common problem is the designated senior rater is not senior enough to evaluate the officer. Often, this occurs because the rated officer has been promoted or selected for promotion during the rating period. When an officer is promoted, the rating chain should be reviewed to determine if a new senior rater is required. For example:

> CPT Smith is rated by MAJ Jones and senior rated by LTC Johnson. Four months into the rating period, CPT Smith is promoted to MAJ. LTC Johnson is no longer eligible to senior rate CPT Smith because the minimum grade for a senior rater of a MAJ is a COL/GS15. A new senior rater must be identified. LTC Johnson, if he chooses and if all requirements are met, can render a Senior Rater Option OER prior to CPT Smith's promotion to Major.

A second example is:

> CPT Smith is rated by MAJ Jones and senior rated by LTC Johnson. Four months into the rating period, CPT Smith is selected for promotion to MAJ. CPT Smith is working in an authorized O-4 billet. LTC Johnson is not eligible to senior rate a CPT(P) who is serving in a Majors position. Therefore, a new senior rater must be designated.

A senior rater qualification matrix is located at Table 2-1 on page 5 of AR 623-105, dated 1 Oct 97. Use this reference as your guide in determining senior rater qualifications. Officers who have had an OER returned due to "senior rater grade not met" know there is no easy fix for these reports. You cannot designate another officer as the senior rater and evaluate the rated officer. Normally, the invalid senior rater narrative is moved to the intermediate rater portion of the OER and a new senior rater is appointed to perform the review function only. **The bottom line is the rated officer gets an OER without senior rater comments and no block check.** So we urge you to discuss senior rater qualifications at your S1/PSNCO conferences and ask them to send you their rating schemes so your clerks can pick up on the invalid senior raters before reports are generated.

7. USE OF NARRATIVE GIMMICKS

The use of BOLD type or exaggerated margins ("picture-framing") has never been permitted when preparing an OER. The rules have not changed under the 67-9 OER system. See AR 623-105, paragraph 3-26 and 3-34. Raters or senior raters, who use BOLD type or "picture-framing" to emphasize, highlight, or bring attention to a rated officer's performance often do the officer a disservice. OERs with BOLD type or "picture-framing" will not be accepted and will be returned to the submitting organization for correction, thus delaying the rated officer's OER from being processed.

8. COMPLETION OF PART VII.a.

Many OERs have reached PERSCOM with this block only partially completed. In addition to the block check evaluating the officer's potential, the senior rater is required to identify the number of officers of the same grade and component that the senior rater rates. When that space is blank, the OER cannot be finalized. Again, this small omission results in unnecessary processing delay since the examiner must contact the senior rater and request the necessary information before the OER can be processed. Or, if the examiner is unable to contact the senior rater, the OER may be returned to the personnel service battalion. By reviewing OERs more carefully prior to mailing to PERSCOM, this should be an easily eliminated error.

9. RELIEF FOR CAUSE OERS

A great deal of time is lost attempting to process incomplete Relief for Cause (RFC) OERs (reference see AR 623-105, paragraph 3-32 and 3-33). To ensure these OERs are processed in a timely manner, several things must be completed. Here is a short questionnaire/checklis] identifying actions required to ensure prompt processing of RFC OERs:

Does the OER identify who directed the actual relief?

- Rater?
- Senior Rater?
- Other? (if outside the rating chain, a memo by the relieving official must be submitted with the OER)

Does the OER require a supplemental review?

- Yes/No
- If it does, is the supplemental review documentation included with the OER when mailed to HQDA?

Who conducts the supplemental review?

- If the rater did the relief, the review is done by the senior rater. The senior rater states he has reviewed the action and it is correct. No additional paperwork is required.
- If the senior rater directs the relief, the first officer in the chain of command above the senior rater must do the review. Memorandum required.
- If someone directs relief other than the immediate rating chain (rater or senior rater), the review is conducted by the first officer in the chain of command above the individual who directed the relief. Memorandum required.

Must the senior rater complete Part VII.d.? Yes. Even if the senior rater has recommended that the rated officer not be retained on active duty, the officer will not be released from the Army immediately. In most cases, recommending positions/assignments where the rated officer can be utilized will assist those responsible for the officer pending further action.

Are the following documents included in the RFC OER packet?

- Acknowledgement of the referral by the rated officer (unless rated officer checked "No" in Part II.d. and signed)
- Comments from the rated officer (if he chooses to make comments)
- Statement by the senior rater if the rated officer refused to sign the OER
- Statement by relieving official, if other than rating officials, with reasons for relief (AR 623-105, paragraph 3-50.c.(4))
- Supplementary Review (unless rater directed the relief)

If any of the required documentation is not included with the OER, processing the OER will be delayed or the OER may even be returned. Therefore, it is imperative that you review the OER carefully before sending it to PERSCOM.

IMPACT of Center of Mass (COM) OERS

- Center of Mass File is different from a Center of Mass Report (many Above Center of Mass (ACOM) officers have COM reports). However, having all COM reports places an officer at risk.
- Most officers have received at least one COM (over 85% of all CPTs; 79% of all MAJs; 79% of all LTCs). These figures continue to rise.
- A COM OER, by itself, is not a killer; all boards select officers with at least one COM report; over 8,000 selected so far (many of those had multiple COMs).
- Most of those who are successful will have a mix of ACOM and COM OERs.
- All (multiple) COM OERs will place you at risk beyond promotion to major.
- Board results indicate officers with a mix of ACOMs and COMs are competitive to LTC.

Enthusiastic, but not over exaggerated, narrative often differentiates among COM reports.

NOTES FROM THE ANC HISTORIAN
"Branson Honors the ANC"
MAJ Debora Cox

On November 8, 2001, aboard a majestic 1890's paddlewheel riverboat, the Army Nurse Corps was honored during Veterans Homecoming Week in Branson, Missouri. Over 40 Army nurses from around the nation were present as 750 combat veterans and family members paid tribute to our 100 years of service to America's Army. Among the distinguished guests were COL Deborah Gustke, Assistant Corps Chief, U. S. Army Nurse Corps; BG Robert Gaylord, Deputy Commander, U. S. Army Recruiting Command; COL Diane Plemenik, Chief Nurse USAREC; BG (Ret.) Connie Slewitzke, 17th Chief, ANC and Vice President, Women in Military Service

for America (WIMSA); COL (Ret.) Eily Gorman, 22nd Assistant Corps Chief, ANC; COL (Ret.) Darlene McLeod, President, Army Nurse Corps Association (ANCA); COL Audre McLaughlin, Vice President, ANCA; and COL Jeri Graham, Commander, Fort Leonard Wood MEDDAC. CPT Heidi Whitscarver, U.S. Army Recruiting Command, served as the honor escort for the POW/MIA service during the gala's opening ceremony.

Following the evening meal, an original Giclée painting, (displayed on front page of this newsletter) created by Mr. Richard Rezac, was unveiled and presented to the U.S. Army Nurse Corps in celebration of the Corps' 100th Anniversary. Pictured below are Mr. and Mrs. Richard J. Rezac presenting the painting to COL Deborah Gustke and MAJ Debora Cox.

Mr. Rezac described the symbolism behind his masterpiece: the background is a golden sunrise signifying new hope and health. Next are the five American Flags that the Army Nurse Corps has served under. The Army nurse images were taken from actual photographs in the ANC Historical Collection, representing the strength, courage, pride, beauty and diversity of this Nation's Army Nurse Corps. The uniforms are duty whites from 1901, the formal dress uniform of WWI and combat uniforms of WWI, WWII (Pacific and European Theaters), Korea, Vietnam, and the Gulf War. The male nurse depicted in the Vietnam fatigues was a soldier who Mr. Rezac served with.

Congratulations on a job well done goes to COL (Ret.), Betty Antilla, AN, who served as primary POC for the evening event and who gave a terrific tribute to Army nursing history at the Branson Veterans Memorial Museum earlier that afternoon! And finally, to all our Army Nurses, past and present, a big thank you for your sacrifice and selfless service for every duty day. God Bless our Corps and our Nation.

*For more information on the painting, see page 18 of this Newsletter.

DEPARTMENT OF NURSING SCIENCE NEWS

The Army Nurse Corps Association (A.N.C.A.) Advanced Military Practice Award

The Army Nurse Corps Association sponsors the Advanced Military Practice Award. This award honors a middle-range ANC officer who has contributed significantly to the practice of nursing during the past 2 years. This annual award is separate and distinct from any others that may be given for particularly outstanding duty performance. Individuals nominated may be any field grade AN officer (CPT(P), MAJ, LTC) except for Colonel or LTC(P) from any component - Active, USAR or ARNG. The nominating individual may be in the nominee's supervisory chain or a peer. However, nominations must include an endorsement by the nominee's chief nurse or senior rater. The nomination should be submitted in memorandum format and should not exceed two double spaced typed pages. Provide specific and factual information, giving a concrete description of what the officer accomplished, the impact of the accomplishment (improves cost benefit ratio, improves quality of care), what the significance of the project is to nursing practice and why this accomplishment merits recognition by the A.N.C.A. and the Chief, Army Nurse Corps. Nominations must be submitted by **21 December 2001** to Chief, Department of Nursing Science 2250 Stanley Rd., Suite 214 Fort Sam Houston, TX 78234-6140. Nominations will also be accepted by fax at CML (210) 221-8114/DSN 471-8114. The letter of Instruction of the A.N.C.A. Advanced Military Practice Award, Standard Operating Procedures, and a sample memorandum are available on the ANC website <http://www.armymedicine.army.mil/otsg/nurse/index.htm> or by calling the Department of Nursing Science at DSN 471-8231/CML (210) 221-8231.

Notification of Changes in the Advanced Nurse Leadership Course (ANLC)

The Advanced Nurse Leadership Course (ANLC) is being converted into a Distance Learning (DL) course due to major funding constraints. The ANLC will be separated into two distinct phases that will continue to focus on executive leadership skills for ANC officers and Department of Army Civilians. Here are some frequently asked questions about the Advanced Nurse Leadership Course.

Question: Can you please explain to me in detail how the new course will work? I understand there is a phase I and phase II. Phase I with a CD ROM and test, Phase II must be signed up for.
Answer: Phase I ANLC utilizes a CD ROM which contains three subcourses and three final exams. The CD ROM is highly informative and not that difficult. Phase II requires enrollment after completion of phase I and is subject to availability from your MTF.

Question: Where do we get the Phase I CD ROM and test?
Answer: The CD ROM is issued by the Nonresident Instruction Branch, AMEDD Center and School to each person once enrolled through ATTRS Distance Learning.

Question: Does the individual contact NRI for the CD ROM and tests?
Answer: NO. The individual signs up for the course through MAJ Gary Lang at PERSCOM for active duty –or- MAJ Mary Fell at ARPERSCOM for reserve officers -or-submit their

name through hospital or nursing education to sign up. ATTRS DL accesses that information on a routine basis and mails the materials to the individual.

Question: How long does a person have to complete Phase I?
Answer: There has been no time limit established for completion. The "average time" to complete the course is twenty-one hours. A more realistic statement would be that individuals could complete everything within a range from 2 - 21 hours. The ultimate goal is to place phase I on the internet, complete with internet testing.

Question: Who grades the Phase I test?
Answer: The Nonresident Instruction Branch, AMEDD Center and School.

Question: What are the dates of Phase I?
Answer: Phase I starts anytime a person is registered and receives the CD ROM. ATTRS DL scans the registration lists routinely and sends out the CD ROM on a routine basis.

Question: Do they mail the CD and tests to your home?
Answer: The CD ROM is mailed to whatever address is indicated.

Question: Does Phase I have to be completed before Phase II?
Answer: Yes. Phase I must be completed, certificate in hand, before enrollment into Phase II.

Question: How many contact hours will I receive for Phase I?
Answer: 21 contact hours.

Question: How many can attend Phase II? How many individuals can your VTT site or DTL (digital training lab) hold comfortably?
Answer: Attendance is limited by site size and MTF mission requirements. If your chief nurse can only allow three people, then your limit is three people.

Phase II dates are
Mar 04 - Mar 08, 2002, 0730 - 1630 Eastern Time
May 06 - May 10, 2002, 0730 - 1630 Mountain Time
Sep 16 - Sep 20, 2002, 0730 - 1630 Eastern Time

Question: Where do people sign up for Phase II?
Answer: This is a two-part answer. Again, it depends upon availability. Either MAJ Gary Lang at PERSCOM -or- MAJ Mary Fell at ARPERSCOM will register individuals.

Question: Do the Phase I and Phase II people get certificates?
Answer: Phase I certificates will be issued by the Nonresident Instruction Branch at AMEDD Center and School. ANLC completion certificates will be issued by the AMEDD Center and School.

Question: Does NESD staff proctor Phase II?
Answer: Proctor is a poor word selection. The education staff responsibilities include reproducing and distributing course materials, maintaining attendance, and insuring problems are handled at their sites. We're utilizing the principles of adult learning here.

Question: What happens to those folks who do not have VTT?
Answer: A listing was sent out for area VTT sites. We can resend the listing. Sites can also bridge to the VTT using a VTC site. Please understand that someone with a higher priority (general officer, hospital commander, chief nurse) can and will bump you from a VTC site, but not a VTT site.

Question: Overseas and OCONUS participants, what happens to them?
Answer: We're seeking funding to TDY those individuals to San Antonio. Selection will be done by an order of merit list.

Question: What would it take to acquire a VTT site?
Answer: Digital Training Labs are funded by TRADOC. It is a long involved process. If you want more information please contact Dr. Carl Wyatt. [SMPT:carl.wyatt@monroe.army.mil]

Question: Who is the point of contact for the ANLC.
Answer: MAJ Irvin Carty, DSN 471-6080, commercial (210) 221-6080. Use his email irvin.carty@cen.amedd.army.mil. I know he hates answering the phone.

Opportunity Knocks For Experienced AMEDD Soldiers

With the transition of 91B to 91W and 91C to 91W M6 comes a unique opportunity for active duty and reserve component AMEDD soldiers. When the AMEDD Center and School implements the new 91W course, inputs for the early 2002 91W/M6 (91C) classes are anticipated to be lighter than usual. Class 01, beginning on 4 FEB, will receive students from the initial 91W classes which are smaller pilot training classes. AMEDD enlisted personnel may take advantage of this "one time" training seat availability and apply for training. This is an outstanding opportunity for those holding or having previously held 91B (91WY2) MOS to attend a training course that allows a soldier to take a national exam for licensure as a practical nurse (LPN) upon completion.

The course is fifty-two weeks in length with the first six weeks at FT Sam Houston. The classes cover anatomy & physiology, microbiology, nutrition, pharmacology, math and the role of the M6 in the AMEDD. Phase II for class 01-02, 46 weeks, will be conducted at DDEAMC or MAMC. It includes 700 hours of didactic instruction in nursing fundamentals, documentation, pharmacology and an in-depth study of the cardiovascular, respiratory, musculoskeletal, GI/ GU and reproductive body systems and associated disease processes. Over 900 hours of training are spent in the clinical arena and include medical-surgical, pediatrics, obstetrics, mental health, ICU and ER rotations. As well, a field-nursing component is included in order to apply the skills to the TO&E environment. It is recommended that you contact the 91C Branch NCOIC, DSN 471-8454, to determine at which site you may be assigned before making arrangements to move household goods and/or family.

The role of the M6/LPN is an essential component of military healthcare and also has prominence in the civilian sector. The Practical Nurse Course is an excellent foundation for further study and many graduates have pursued advanced nursing degrees after completing this program. Check with your Hospital Education Department and they will assist in the application process.

USAREC NEWS
COL Diane Plemenik

Good news and bad news on the recruiting side of the house…the Army Reserve mission overall was exceeded for FY01 with overproduction in the critical 66H8A and 66F AOC's, but the Active mission fell short. This FY, the challenge is even greater with an increased mission of over 200 new Army Nurses. You may be called on by local AMEDD Recruiters to assist in various recruiting activities. We all have a vested interest in bringing in quality nurses…and we are all recruiters! Your assistance and support of nursing colleagues and your chain is greatly appreciated.

During this past year, the US Army Recruiting Command has taken many opportunities to highlight the centennial of the Army Nurse Corps in the civilian community. Of special note was the National Student Nurses' Association Convention in Nashville, TN. Every year at this event, the Spirit of Nursing Award is presented by the Chief, ANC to a nursing student selected from among the nation's nursing programs. The ANC was showcased at this event by officers from WRAMC who presented the colors at the opening ceremony, showing the ANC history film, and by having the best booth at the exhibit! USAREC and ROTC personnel, as well as the WRAMC officers staffed the booth.

Because of their stellar performance, the WRAMC officers were invited to the opening ceremony of the Emergency Nurses' Association; unfortunately the conference was scheduled for 11 Sept. However, they did represent the ANC at the opening of the New York State Nurses' Association meeting in NYC in early Nov. Many thanks to CPT Jeff Schrader, 1LT Noelle Flynn, 2LT Adrian Gailey, 2LT Larry Herring, 2LT Rachel Woolfolk and 2LT John Yauger for their recruiting efforts and for being exceptional ambassadors of the ANC! Also noteworthy was the American Association of Nurse Anesthetists Annual Meeting in San Francisco where the opening ceremony was dedicated to the ANC. BG Bester attended this event as well which included a film of the contributions of Army Nurse anesthetists to the profession. Major Debora Cox and LTC Tim Newcomer worked with other Army CRNA's and members of the AANA to produce a truly wonderful video. One of the highlights of this conference is the USAREC sponsored "College Bowl." Of course, a team with an ANC on it was the winner! Thanks again to all those who participated in and supported recruiting efforts during this centennial year.

NURSING RESEARCH UPDATE
"Congressionally Directed Medical Research Programs: The Army Administers a $2 Billion Research Funding Organization"
LTC(P) Stacey Young-McCaughan

In the past decade, the work of consumer advocacy organizations has dramatically influenced the way scientific research is funded in this country, resulting in congressional appropriations targeted at research in specific diseases. Beginning in fiscal year (FY) 1992, the United States Congress directed the Department of Defense (DOD) to manage several appropriations for an extramural grant program directed toward specific research initiatives. The United States Army Medical Research and Materiel Command constituted the office of the Congressionally Directed Medical Research Programs (CDMRP) to administer these funds in a responsible way. To date, between FY92 and FY01, Congress has targeted almost $2 billion to the CDMRP for research on breast cancer, prostate cancer, ovarian cancer, neurofibromatosis, defense health, and other specified areas. Together, these programs comprise the CDMRP.

Army nurses have always been involved in the leadership of the CDMRP. COL Patricia Trumbly was the first Director of the program followed by COL Irene Rich who served as Director until her retirement in 1999; LTC Stacey Young-McCaughan is currently the Deputy Director. Working with these programs has given Army nurses and Army nursing a tremendous opportunity to learn about the congressional appropriations process and the management of a multibillion-dollar program with intense public and congressional interest.

The CDMRP has been a pioneer in exploring innovative program management strategies that are now being piloted by other funding agencies. Examples of innovative program features born within the CDMRP are the participation of consumer advocates in all aspects of program development and research evaluation, the two-tiered review process, and the criteria-based scoring system used in the scientific review of research proposals. In addition, the Idea Award was first developed by the CDMRP with the hope of funding higher risk, but potentially higher gain ideas that would strategically advance the given field of study.

The research accomplishments of the CDMRP can be gauged, in part, by information reported in scientific peer-reviewed journals. FY92-97 awardees have reported over 2,300 publications, 1,800 presentations, and 30 patent/license applications on work accomplished with DOD funding. Individual research projects have made significant contributions to our understanding of disease processes, the development of therapeutics, and the improvement of quality of life. For example, the research on HER-2/neu oncogene expression has led to the development of Herceptin, an anti-HER-2/neu breast cancer therapeutic agent currently used in civilian and military medical centers. Similar studies are being conducted to elucidate prostate cancer-specific oncogenes. Researchers are also targeting the process of

angiogenesis as a potential area for early intervention in both breast and ovarian cancers. Other research demonstrated that when cared for by an Advanced Practice Nurse, there was an improved quality of life for a group of women newly diagnosed with breast cancer and undergoing mastectomy; there were no additional costs associated with this care.

The majority of proposals submitted to the CDMRP are from civilian universities and institutions, although military institutions and laboratories are eligible to apply. Investigators from Walter Reed Army Institute of Research, Tripler Army Medical Center, and Madigan Army Medical Center have all successfully competed for funding from CDMRP programs. The CDMRP is always interested in receiving proposals from military researchers, including nurses. Once the Defense appropriations budget is finalized, the call for proposals for the FY02 programs should be published early next year.

Another way to learn more about a specific CDMRP program is by serving as a Government Liaison. Government Liaisons act as observers for the peer review panel sessions, ensuring that appropriate procedures are adhered to and that controversial issues are recorded during the review process. The 3-day scientific peer review meetings are held in the Washington, DC area. CDMRP funds temporary duty expenses to bring Liaisons in for the meetings. Previous Government Liaisons have found the peer review process to be interesting, informative, and useful in providing insight into how science is reviewed. There are no educational requirements for participation; however the program prefers that Government Liaisons have either a masters or a doctoral degree since a clinical or scientific understanding of the panel's scientific discussions usually results in a more rewarding experience for the Liaison. Information about being a Government Liaison is sent out to the Regional Nursing Research Coordinators and Chiefs of the Departments of Clinical Investigations in February or March. Interested personnel who have approval from their supervisor, can respond to this email or can contact LTC Stacey Young-McCaughan at stacey.young-mccaughan@det.amedd.army.mil.

Overall, the CDMRP exists to support research that will impact the health of all Americans. Army nurses have led this organization since its inception and there continue to be opportunities for nurse involvement in various aspects of the programs. Additional information regarding all of the programs of the CDMRP, including highlights of funded research, the inclusion of consumers in the program, and funding opportunities can be found at http://cdmrp.army.mil.

PSYCHIATRIC COURSE NEWS
"The (66) C's are in D.C."
LT Joellen Schimmels, 66C Student

Well, we are just over half way finished with the 66C Course—what a time to move it to Washington D.C.! This is the first Psychiatric Nursing Course here at WRAMC. There are only three students (our theory is that it has to do with the new location), but we are an eager bunch ready to start as psych nurses.

Psychiatric nurses are by nature extremely easy going and flexible. At least the three of us have been. These are traits that we are finding an absolute necessity in this situation. Power outages, terrorist attacks, anthrax, an unfinished classroom and little computer access make the painted shut (then painted open) windows seem rather minor.

We are told that the course is going through a lot of changes and revisions as it goes on. We are in a self-proclaimed "guinea pig status," which we are finding is a good fun loving way to describe our experience at the 66C course. "It is just bad karma," states fellow student CPT James Perrine. This has been a time for us to give input and suggestions on improving the course for the future.

At least our instructors are flexible as well. They are both great. With everything going on, it has been very stressful and hectic. They have both been extremely helpful and committed to the course. We have been learning a lot of information and are doing a number of useful presentations and papers. There are even a few exams (I know, but there had to be.) I think the small class size has been beneficial to getting the course started in the new location.

After a month of didactic instruction, we spent about a month on the inpatient and outpatient units at WRAMC. Currently, we are at a substance abuse and addictions program at Andrews Air Force Base. Soon, we will go to the Soldier and Airman's Hospital. I am pleased to see the wide variety of experiences that we are getting in the D.C. area. The staffs that we have worked with were terrific and we could not ask for better clinical experiences.

Of course, being in the D.C. area opens doors for lots of sightseeing and experiences that we could not get anywhere else. I don't know that I would have picked D.C. for the new course location, but this is the Nation's Capitol. There are lots of museums, shopping and dining experiences available that make this a great place to spend some time.

Graduation is just around the corner, 20 December is the date (now that the course is only four months long.) We are all very excited. I just hope that the ANC is ready for three eager young soldiers as 66C's. We are heading off to Tripler and Korea, and one student is staying right here in Washington D.C.

I would encourage anyone interested in psychiatric nursing to get their application in right away. I am sure that the classes are filling up (or at least we need your help in doing so!)

DIRECTOR, HEALTH PROMOTION AND WELLNESS, USACHPPM

LTC(P) Gemryl L. Samuels

A couple of days ago, just before the Thanksgiving holidays, a call came into our office from the office of an Army Division Surgeon requesting prepared information related to health and wellness as well as prevention of disease and injury around the holiday season. There was also some interest in safety information. With little or no hesitation we referred the caller to the Hooah 4 Health web site at http://www.hooah4health.com/ and further requested that a visit be made to the Program Overview page, click on Site Map, scroll down to Hooah 4 Life and there in the right hand corner will be information on holiday safety, holiday blues, winter and toy safety. Tons of internal and external links, all of which can be printed and packaged for use are all located there.

If by now you're becoming interested in Hooah 4 Heath, let me tell you more. Health promotion is a key factor in optimal soldier readiness and health maintenance. However, no comprehensive health promotion program was available to the Reserve Component (RC). The Office of The Surgeon General (OTSG) requested the assistance of the Directorate of Health Promotion and Wellness (DHPW), United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) in developing a program.

Hooah 4 Health is based on an interactive web site, which became operational on 1 May 2000 and has been selected for the Joint Chiefs of Staff Force Health Protection Awareness Program. The site contains educational materials in the area of physical, mental, spiritual, environmental/occupational health, behavioral change theory, and prevention. Its development is complete, although continuous updating is ongoing. The site is linked to numerous government sites. Both process and outcome evaluation research is being conducted with site users, including the collection of baseline health risk and health goals information.

The "Hooah Challenge", a correspondence course was launched in October 2001 and is the first web-based correspondence course developed by the Army Medical Department. The site also contains a toolbox of materials for publicity, promotion, teaching classes, and preparing briefings.

The Army RC in conjunction with the Veterans Administration has been planning to field a web-based health assessment that would provide longitudinal information on the health of soldiers throughout their careers and retirement. Hooah 4 Health was selected to be that vehicle for disseminating the assessment. Since the terrorist attack on 11 September, the development of this product has been accelerated. The survey instrument, the Annual Health Certification and Survey (AHCS), is in its final draft form and it is anticipated that it will be beta-tested in December 2001. The survey contains 25 questions that assess changes in health and health risks over a one to twelve month time span.

Since active marketing of the site began in November 2000, it has been used extensively, with 90,000 hits in November 2000, compared to 3,546,816 eleven months later. Visitors originate from the United States, Europe, Asia, Australia, Canada, Africa and South America, and spend at least three minutes at the site.

Have you visited Hooah 4 Health? Are you being deployed? Do you have a family member or friend who is being deployed to another country? Why not find out about deployment areas to include Afghanistan by visiting the Online Deployment Globe? Links to useful web sites and other resources for deployment are also provided. Need information on fitness, nutrition, work out for your mind, suicide, President Bush's Address to the nation after the 11 September attack on America? How about healthy recipes for the holidays? Hooah 4 Health provides a huge database of recipes including special diet categories for restricted and special diet. Take time today to visit Hooah 4 Health. Hooah!

Community Health Nurses Sustaining Competency in Community Health Nursing – Article Review

LTC(P) Sandra L. Goins

In recent years, the health care system has been challenged to objectively define its impact on the care and services that it provides. Subsequently, there has been a major focus by the AMEDD on assessing, defining, measuring and documenting quality care services. A major component of quality care is competency of the providers. Education and credentials often define entry level competency. However, after the initial practice year, continuing education and training is necessary to sustain and maintain competency. Public health professionals are not immune! We too, must develop and provide relevant continuing education to maintain competency.

In 1988, the Institute of Medicine published a landmark document *The Future of Public Health.* Although more than a decade old, this document remains a catalyst for many current

initiatives we see in public health today. A key challenge in this document is to improve public health practices. As a result, several public health disciplines- including public health nurses (PHN/CHN)- have accepted this challenge and are diligently working to document plans to improve.

In the *American Journal of Public Health* article, "Preparing Currently Employed Public Health Nurses for Changes in the Health System", Kristine M. Gebbie, Dr PH, RN and Ineson Hwang, MS, RN, describe a project to assess the needs of the PHNs in the current health system. This study used two focus groups of 25 participants to (1) define the skills most needed by PHN's to successfully function in the health system and (2) develop a continuing education and training curriculum to address these needs.

There are many relevant issues from the article worthy of discussion, but due to time constraints and space, I have selected three key points to review here.

First, the group redefined public health nursing to be "nurses whose primary focus is populations or groups." Their reasoning was based on the observation that many PHNs are not baccalaureate prepared, but many public health agencies employ nurses with different levels of preparation. This is in contrast to the American Public Health Association (APHA) Public Health Nursing Section, which states "public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social and public health sciences". Though current standards require baccalaureate preparation for most CHN positions, the education and experience of our CHN inventory (military and civilian) varies from diploma graduates to Ph.D. prepared and no previous CHN experience to more than 20 years experience.

Secondly, the first focus group listed more than sixty internal and external forces that impact PHNing. This non-exhaustive list included changes in economics, technology, health and illness, care systems, government, social forces and forces specific to nursing. Other examples are managed care, new issues of teen pregnancy, violence, inability to reform health care from medical to prevention, confusion about different levels of public health nursing and emerging environmental knowledge.

Finally, the second focus group compiled the list of skills and knowledge most needed by PHNs and developed a two year continuing education training curriculum to address the challenges noted by group one. Some skills and knowledge identified included epidemiology, organizational change skills, measuring health status, connecting to organizations, environmental health policy, negotiation, communication, advocacy, collaboration, data analysis and statistics. They identified the "frontline" or staff PHN as the target for training, although supervisors, nurse practitioners, nursing faculty, and administrators may benefit. This curriculum can be an objective model for continuing education for AMEDD CHN's military and civilian.

In summary, this study reviewed established core competencies and input from PHN's (staff, academia, state and federal administrators) to identify training needs to ensure competency in the core functions of PHNing. I highly recommend review of this article for the listing of forces affecting public health nursing practice; the list of skills and knowledge most needed by public health nurses and suggested content for PHNing continuing education.

This article can be found in the *American Journal of Public Health*, 90 (5) 716-721, 2000.
You can obtain a copy of this article by going to www.apha.org – access to this journal is currently free.

Please contact me for CHN concerns at DSN 236-7410/0370 or (910) 432-5517 or at sandra.goins@amedd.army.mil.
Wishing you a safe and enjoyable holiday season! CHNs – Caring , Competent and Committed!

Honduran Nursing Seminar
JTF-Bravo, Honduras
CPT Emily R. Wassum, EMT OIC

Twice in the first three months of my assignment at Joint Task Force-Bravo the nurses of the Emergency Medical Section have hosted a comprehensive nursing seminar for up to 38 Honduran nurses from 6 different hospitals. They address topics from basic nursing care to ECG interpretation and advanced cardiac life support (ACLS). The nurses prepare each presentation, coordinate classrooms and equipment, and provide lunch in the dining facility. Detailed planning must be done in order to bring civilians on to Soto Cano Air Base. Honduran liaison officers assist the nurses in this process by contacting the hospitals and issuing invitations. Passes onto post must go through the post chain of command and are issued by the Honduran Commander.

On the day of the seminars, the nurses focused on promoting a relaxed atmosphere for exchange of ideas. 1LT Bridget McIlwain, Dwight D. Eisenhower Medical Center, said of the first seminar, "We didn't really know the skill level of any of the nurses or how well we could get them to participate. But as the day progressed we were happy to see our presentations become more like panel discussions. We started the morning off with presentations and in the afternoon we did round robin skill stations."

In the first seminar the topics covered were basic nursing practices, such as, the nursing process, care of the surgical and medical patient, and physical assessment. We were pleased to find that the Honduran nurses were taught these concepts in nursing school. However, when LT McIlwain started the portion of her presentation on nutrition we quickly saw where principles diverged. "Honduran nurses don't teach the four food groups because many Hondurans don't have access to meat, poultry, eggs, or dairy products. Patients here are taught how to best use what they do have available," said LT McIlwain.

The second seminar was completely cardiac focused. Topics covered were ECG interpretation, acute myocardial infarction, congestive heart failure and BLS/ACLS. In the afternoon sessions the nurses practiced intubation and learned how to use the ECG machine and defibrillator. Only a third of the nurses at the seminar were familiar with these machines. The private hospitals are more fully equipped, but the public hospitals, which most Hondurans utilize, have next to nothing. Honduran nurses must rely on empirical methods of treatment. At the end of the day the nurses fill out an evaluation form and are asked what topics they would like to see in future seminars. Most nurses said their favorite parts of the day were the hands on practice with scenarios and equipment. They wanted to see topics focusing on care of the ventilated patient and the critical care patient. So, our next seminar is scheduled for January and will be pulmonary and critical care oriented.

Through these seminars JTF-Bravo nurses are honing their organizational and presentation skills, as well as becoming subject matter experts on various nursing topics. Most importantly, they are learning about the health care system of their host nation, as well as fostering a relationship with Honduran health care professionals who could potentially be caring for U.S. soldiers.

"THE FUTURE OF CRITICAL CARE TRANSPORTS"

CPT Teresa Duquette
U.S. Transportation Command, Global Patient Movement Requirements Center

The critical node in the process of patient care and evacuation from the front-line to a Level IV hospital is the transfer of patients from a forward Army hospital to the United States Air Force (USAF) strategic evacuation system. Stabilizing and transporting a critically injured soldier while maintaining the high level of monitoring required during transport, continues to create numerous challenges for medical personnel, in both air and ground transports, thereby placing extensive burdens on the already limited logistical system. At present, the military uses individual pieces of monitoring equipment in order to create a functioning platform for the critically injured or ill soldier. This concept requires medical teams to hand carry equipment such as: cardiac monitors, suction units, ventilators, defibrillator, pulse oximetry and fluid infusion pumps, in addition to the medical supplies and medications needed to provide resuscitative and life-sustaining treatment.

The Life Support for Trauma and Transport (LSTAT) is an individualized portable intensive care unit (ICU) for resuscitation, stabilization and evacuation of trauma casualties. The unit travels with the casualty and serves as the interface to the various evacuation vehicles, both air and ground, and can be used stand-alone in an austere environment or interfaced with existing external power and oxygen sources. Currently not all equipment available at an Army Medical Treatment Facility (MTF) is approved for flight. When transporting this type of patient, time is required for the transfer of equipment carried by USAF aeromedical personnel. The disconnecting and reconnecting of equipment can be very time consuming and possibly detrimental to the critical patient, especially in the austere environment. The LSTAT platform has been designed to allow medical personnel the ability to stabilize and transport with the embedded equipment from the point of injury all the way through the evacuation system to definitive hospital care.

The LSTAT Components:
The medical functionality of the LSTAT consists of air-approved equipment separately utilized by the USAF aeromedical evacuation system today. Based on lessons learned from Desert Storm, Dr Frederick Pearce, Chief of Resuscitative Medicine at Walter Reed Institute of Research developed this unique concept called LSTAT.
Integrated Medical Systems, Inc built this platform using the following items; a PROPAQ monitor that includes a Non-Invasive Blood Pressure, 2 Channel Invasive Pressure Monitoring, Electrocardiogram (ECG), Pulse Oximetry (SP02), End-Tidal C02 and Temperature (skin and esophageal). The Impact 754 ventilator is also integrated into the system, which includes Airway Flow/Volume measurement; this is an electronically controlled ventilator with internal compressor and an air/oxygen mixer, supplying patients with medical grade air and oxygen. Gases may be blended from any combination of external oxygen or internal oxygen source and internal compressor or external compressed air. The ventilator provides a gas mixture of 21-100%.

The on board oxygen subsystem has the capacity to hold 480 liters at 3000 psi and is refillable. There is an oxygen bypass port available for nasal cannula or facemask use and requires only a regular flowmeter. An IVAC Alaris 3-Channel infusion pump delivers fluids or medications at 0.1 to 999 cc/hr on each channel. A Semi-Automatic External Defibrillator monitors, analyzes and shocks patients who are in full cardiac arrest. The Impact 326 suction unit with continuous or intermittent mode also has dual canister capability. The *I-stat* is a portable handheld clinical analyzer for blood chemistry using commercial cartridges and is completed within 2 minutes.

All of these medical devices are linked to the Data Display and Logging System (DDLS), which records physiological data for the patient and status of the LSTAT equipment. It has a secondary display that can be wireless or tethered and enables the clinician to see both secure patient and LSTAT data from anywhere, including from a computer monitor when the LSTAT is connected to local area network and/or the Internet. The power subsystem can accept 50-400 Hz / 110-220V and 28 DC power input and uses a total of 3.3 amps when all equipment is powered on. The unit carries the

different pigtail adaptors for the electrical outlets found in the various evacuation transport platforms to include the typical 3-prong household plug for 60Hz-110V.

The LSTAT battery will run approximately 2hrs with all equipment running. When unit is connected to auxiliary power and the Trickle Charge is on, the internal batteries will be kept fully charged. Specifications: 165lbs, 13" high at head faring, 22" wide and 85.5" long.

LSTAT Employment:
The LSTAT has been used in both exercise and mission employments. Surgical teams from multiple Combat Support Hospitals (CSH) and personnel from the Forward Surgical Teams (FST) have performed over 50 real surgeries using both ISO-Shelters and GP tents during various field exercises throughout the Army. The concept for the LSTAT is to perform surgery on a single platform, monitor the patient and be able to transport not only within the facility but also to a higher level of care if required without ever having to disconnect from the monitoring and treatment capability. This concept provides for a unique situation termed "Damage Control" surgery, performed for the initial stabilization, the patient is then brought to the ICU for re-warming, hemodynamic and physiological monitoring prior to returning for more surgical intervention or the urgent transfer to an appropriate facility.

These exercises provided not only valuable data for the physiologic monitoring of patients but enabled the surgical staff to evaluate the LSTAT's overall performance within the field environment for both Echelon II and Echelon III Combat Health Support Care.

In July 1999 the 67th Combat Support Hospital (CSH) initiated a *Trauma Log* and documented mechanisms of injuries seen. These injuries included: gun shot wounds (GSW), stabbings, motor vehicle accidents (MVA), mine, grenade, explosions and traumatic penetrating/blunt type injuries from falls, suicides and burns. A total of 322 major traumas were brought to this U.S. Hospital at Camp Bondsteel. The breakdown for the different mechanisms were: 79 GSW, 121 MVA's ranging from minor to extensive, 38 mine, grenade and/or explosions, 71 falls/suicides/burn injuries and 13 complete amputations. Analysis of traumatic injuries by groups were U.S. Army: 15%, Local Nationals: 71%, NATO: 9%, Other (detainee, civilians, and AD other): 5%. With this tempo of trauma patients seen in Kosovo an opportunity exists not only for the upgrade of critical care transports but also for the overall management of trauma patients seen within the Combat Health Service Support.

In Feb 2000 the 212th Mobile Army Surgical Hospital (MASH) from Wiesbaden Germany trained personnel on the LSTAT during their Mission Rehearsal Exercise in preparation for the deployment to Kosovo in support of Task Force Falcon. The 212th MASH replaced the 67th CSH April 00 and began utilizing the LSTAT for all the trauma patients brought into the Emergency Medical Treatment (EMT) section. This unique opportunity afforded all personnel a chance to evaluate the organization of equipment and supplies that are paramount in the success of stabilizing and resuscitating trauma victims where time can mean the difference between life and death.

Also noted in the 67th CSH *Trauma Log* were medical evacuations: 102 patients were transported by either air or ground ambulance to local hospitals. Of the 102 transports; 54 went by ground ambulance, 35 went by air ambulance and 13 were strategically evacuated back to Germany. Soldiers from the 557th Ground Ambulance Company, Wiesbaden Germany, provided the mission for transporting to the University Hospital Pristinia, Gjiilani Hospital or to the University Hospital Skopje Macedonia, sometimes requiring a ground time move of anywhere from 1 to 8 hours. Medics worked on configurations to support the type of requirements needed when caring for critical patients during evacuation and according to Chief Nurse, LTC Suzan Denny, the nurses and internal medicine physician, "highly commended the capabilities of the LSTAT", stating there was "no better way to move critically ill patients". The Kosovo experience with the LSTAT highlighted the absolute necessity to transport critically injured patients under a higher standard of care and with greater efficiency and capability.

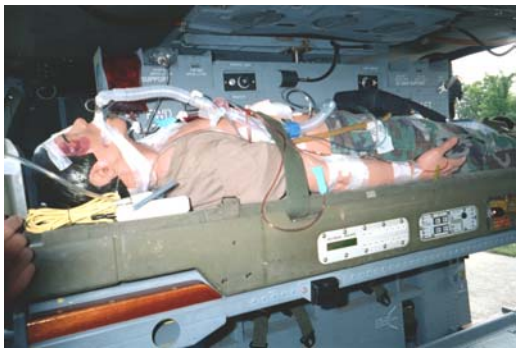
The LSTAT consolidated configuration saves a significant amount of cube space not only for packing containers and pallets, but also within the EMT and ICU areas. This arrangement would provide both Echelon II and III facilities more space within these sections allowing for additional beds when needed.

In Feb 2001 Walter Reed Army Institute of Research brought the LSTAT to ***Pacific Warrior***, an Army/Air Force/Navy exercise held in Hawaii for the combined joint medical training in resuscitative surgery, patient holding and the medical evacuation using both fixed/rotary wing assets. The objective for the LSTAT was to move through the different echelons providing clinicians the opportunity to assess current capability versus LSTAT and then provide recommendations for design enhancement. USAF Aeromedical Evacuation Crews and aircraft crew chiefs were provided an opportunity to evaluate LSTAT capability and then provided input related to the unique airframes used in the strategic evacuation system today.

During this exercise the LSTAT was flown on a C-141 with a Critical Care Air Transport Team (CCATT). These staff members evaluated LSTAT and were impressed with the "arrangement of the high tech equipment" and the ability to provide a "decreased risk of configuration issues compared to the current practice with lines, tubes and equipment placed over the litter".

Currently, all aeromedical flights are flown with separate pieces of emergency equipment strapped down to a NATO litter, this litter serves as the emergency "crash cart" with a second litter required for the patient to be placed on. Today, USAF aeromedical evacuation squadrons can use the LSTAT to provide an organized emergency litter for all flights.

Currently the LSTAT remains in Kosovo at the Military Hospital, Camp Bondsteel and has also been sent to Kuwait at the request of the CENTCOM Surgeon General. The USAF Small Portable Expeditionary Air Rapid Response Team (SPEARR) and the Critical Care Air Transport Team at Elmendorf Air Force Base Alaska utilized the LSTAT during the International Arctic Search and Rescue Exercise Sept 2001. The 207th Army National Guard (ANG) Search and Rescue Unit at FT Richardson, Alaska provided, rotary wing support for this exercise moving the SPEARR and CCATT teams to the casualty site followed by patient evacuation. The 207th ANG will be evaluating the LSTAT over the next 6 months during both medical evacuations and Crash/Search and Rescue (CSAR) missions using the UH-60 Black Hawk.



During Aug 2001, personnel assigned to the Det-1/24th Army National Guard MED CO Air Ambulance from Topeka Kansas and personnel assigned to the 14th Army Field Hospital from Indiana received training on the LSTAT for utilization during ***Bright Star***, an exercise held in Egypt OCT 2001.

Within all these exercises the LSTAT was shown as the best device to support critical care movements during military operations and represents the future for increasing survivability during transport of the critically injured soldier.

Currently Walter Reed Army Institute of Research and Intergraded Medical Systems, Inc are working on two distinctive components, the Patient Isolation Cover and the Environmental Protection Canopy. This capability will provide military and civilian medical personnel enhanced performance in the fields of chemical, biological casualties and cold weather environments.

The Army has been a leader in the development of field medicine and has always brought the highest standard of care in any type of environment supporting soldiers. The LSTAT is needed now for these contingency operations and peace enforcement missions so we can treat and transport our soldiers under the best of conditions, without risk or further injury. In addition, use of the LSTAT now will allow combat health support developers the data needed for future innovations and improvements in trauma treatment and transport for the future.

REFERENCES

1. Integrated Medical Systems, Inc. Life Support for Trauma and Transport (LSTAT). Model 9602. Manual (1997-2000). Signal Hill California. http://www.LSTAT.com
2. Dr Frederick Pearce, Chief, Department of Resuscitative Medicine, Walter Reed Army Institute of Research. FT Detrick, Maryland. July 2001.
3. Suzan Denny, LTC, AN. CN, 212th Mobile Army Surgical Hospital. Life Support For Trauma and Transport Presentation. Asia - Pacific Military Medical Conference. New Zealand. May 2001.
4. TF MED FALCON Trauma Log. U.S. Military Hospital, 67th Combat Support Hospital, Camp Bondsteel, Kosovo. July 1999 to July 2000.
5. Pacific Warrior Exercise. Participant Evaluation Forms for LSTAT. Hickam AFB, Hawaii. Feb 2001.

AEROMEDICAL ISOLATION TEAM

CPT LeRoy A. Marklund

The Aeromedical Isolation Team (AIT) is maintained, under the Command of COL Edward M. Eitzen Jr., at the United States Army Medical Research Institute of Infectious Diseases (USAMRIID), located at Fort Detrick, Maryland. The AIT is a unique military medical team capable of worldwide air evacuation and management of a limited number of patients who are potentially exposed to known and unknown lethal communicable diseases or biological agents. The mission of the AIT is worldwide air evacuation of these types of patients under the highest level of biological containment to USAMRIID for definitive medical treatment. Using a specialized method of air evacuation, the team assists with early identification of highly contagious diseases or suspected biological warfare agents and provides information used to develop early treatment recommendations for health care professionals.

The AIT also participates in the Specialty Medical Augmentation Response Team (SMART) concept of operations. The SMART concept provides the U.S. Army Medical Command with specialized medical teams that can be rapidly deployed for various types of military and humanitarian operations. Of most importance, the only unit called upon by the Department of Defense to safely air evacuate patients exposed to highly contagious microorganisms is USAMRIID's AIT. With these stringent requirements, training is essential to keep the AIT at a high level of readiness.

On August 18-19, 2001, the AIT demonstrated the unique process of containment patient care and air evacuation with the 167th Aeromedical Evacuation Squadron (AES), which is an Air National Guard unit for Martinsburg, West Virginia. The 167th AES provided a C-130 Hercules aircraft and aircrew for the purpose of air transporting the AIT's equipment and personnel for two separate public demonstrations. The entire joint training exercise was conducted under the watchful eyes of 45,000 spectators who attended the Frederick Air Show. This annual aviation event was held at the Frederick Municipal Airport, Frederick, Maryland. The Frederick Air Show was a golden opportunity for the AIT to practice initial containment patient care under realistic conditions.
The importance of initial containment patient care is to ensure that a highly infectious disease will not spread beyond the contaminated area, while the patient is in route to USAMRIID. The process of this unique patient care begins by removing the patient's contaminated garments, decontaminating his/her skin, and placing him/her on a Reeve stretcher. The flight

medic assesses the patient and provides necessary medical treatment to stabilize him/her for aeromedical evacuation. In addition, using the Reeves stretcher, the other team members move the patient closer to the stretcher isolator. Once the patient is positioned and physically stable, the AIT inserts the patient head first through an open portal into the stretcher isolator's impermeable poly-vinyl-chloride (PVC) plastic envelope. As the patient is situated inside the transparent plastic vestibule, oxygen is provided to him/her while the stretcher isolator's portal is capped and sealed with two elastic bands. The battery powered negative pressure high efficiency particulate air (HEPA) filtration system is started completing the process of initial biological patient containment care under biological safety level-4 (BSL-4). The unique feature of BSL-4 is that pathogenic organisms remain inside the plastic envelope during the entire air evacuation. This type of containment system protects both health care providers and aircrew members.

The AIT did not feature the decontamination station and enplaning onto the awaiting fixed winged aircraft. Instead, the sealed stretcher isolator was carried back to the AIT's display booth after both training exercises. This was necessary due to time constraints and the other activities scheduled for the Frederick Air Show. After both demonstrations, all team members interacted with numerous air show enthusiasts who expressed great interest in the duties and training of the AIT.

The AIT members who participated in the 2001 Frederick Air Show were CDR Robert Darling - Chief, Aeromedical Isolation Team & Flight Surgeon, CPT LeRoy Marklund - Flight Nurse, SSG James Packard – USAMRIID Medical Division's NCOIC, SPC Caleb Mick – Flight Medic, SPC Gary Bush – MOS 91K, SPC Robert Volk – MOS 91K, SPC Shari Thompson – MOS 91B, PFC Jennifer Cassity – MOS 91K, and PFC Sherla Smith – MOS 71G.

AIT training at the 2001 Frederick Air Show – photograph by Mr. Charles Boles

The AIT members also extend their appreciation to CPT Robert Williams – USAMRIID Medical Company Commander, SFC Ann Wyant – USAMRIID Virology Division's NCOIC, SGT Alan Owens – USAMRIID Visual & Audio Department's NCOIC, SPC Joseph Trowbridge USAMRIID Visual & Audio Department's photographer, and Mr. Charles Boles USAMRIID Visual & Audio Department's photographer for their support during the Frederick Air Show.

COMMUNITY HEALTH NURSING MEETING NEW CHALLENGES

Hope Cooper-Oliver, MSN, MPH, RN, CDE
Community Health Nurse
Tripler Army Medical Center

Imagine……

- Having to watch your child stick her little fingers 4 to 6 times a day (or having to stick your infant or toddler's little finger).
- Having to give your child 3 to 6 shots a day.
- Having to plan and keep on a tight and consistent schedule every single day: testing and medications, meals and snacks, exercise; trying to avoid – and manage stressful events, bedtime… and most life activities.
- Watching every single number on the meter and scared to death that the "bad" ones will soon cause blindness, kidney failure, amputations… and an early death.
- Watching your child's behavior change dramatically back and forth right before your very eyes.
- Grieving at the loss of your dreams as you worry about your child's future opportunities for career, financial security, a normal life, and for life itself.

…..And you're a very scared parent certain that you will outlive your child who has diabetes.

This is how I usually begin a class at the Child Development Center (CDC) and schools in the community to get the staff to think about diabetes and the effect it has on families.

Now, imagine a 3 year old girl with curly blonde hair, red cowgirl boots, red cowgirl hat, a vest and jean skirt walking in and giving me a picture she drew of herself with a message that read "thank you for coming to my school and teaching me about diabetes, now I can go to school and I love school".

My heart melted. It was well worth the trip to the CDC to teach the staff about Children with Diabetes (CWD). Through the years, community health nursing has always responded to the communities changing needs. The current need in our community is to educate our CDC's, family childcare, after school care, public and private schools about the challenges a child with diabetes faces daily. By teaching them about Children With Diabetes - it enables the staff to provide a safe environment for the child.

The education program consists of the following:

- management of diabetes in children
- signs, symptoms & treatment of low/high blood sugar in children
- effects of insulin in children
- exercise for children and effects of exercise on blood sugar
- how to check blood glucose and what the numbers mean

The education program is presented in an informal style with ample time for questions. The hands-on portion consists of demonstrating blood glucose monitoring.

The staff, once educated/trained, feel confident and less anxious about caring for a child with diabetes. The parents feel less stress sending their child to day care/school/CDC because they have confidence in the staff. The staff has support of the Community Health Nurse (CHN), Certified Diabetic Educator (CDE), families, and medical team, so they know they can call when they need help. The staff starts out fearful and terrified and after the class the staff emerge ready for the challenge.

NEWS FROM AROUND THE AMEDD

12th Annual Phyllis J. Verhonick Nursing Research Course *Military Nursing Research: Meeting the Challenges of Readiness in Healthcare*

Call for Abstracts & Papers
Abstract Submission Deadline: 17 December 2001
Paper Submission Deadline: 25 February 2002

Abstract Requirements

- All research and research utilization topics are welcome
- Research must have been initiated and/or completed in the last 5 years
- Research must be completed by the time of submission to be eligible for a podium presentation
- In-progress or completed research/projects are eligible for a poster presentation
- Funding source(s) should be noted on the abstract
- Follow abstract guidelines (see: www.usuhs.mil/tsnrp/announcements) or send email request to POC: linda.yoder@na.amedd.army.mil
- Abstracts must be limited to one page except for research utilization, which is allowed 2 pages
- All selected abstracts will be reproduced in a book of proceedings. Submission implies organizational approval to reprint the abstract
- Abstracts must be received by deadline: *17 December 2001*
- A blinded review of abstracts will be conducted by expert reviewers
- Podium presentations will be 15-20 minutes in length

This will be an exciting, dynamic research course
Mark your calendars now to attend!!!!

"The Nation's Health: Action Through Public Policy" 10th Washington Health Policy Institute

The Helene Fuld Health Policy Leadership Fellows Program including the Policy Institute conference is on 2-7 June 2002. **Scholarship application deadline is 21 December 2001.** This conference features speakers from Federal and State health agencies, congressional representatives, media experts, influential leaders and organization representatives from Washington D.C. All participants learn about political and policy process and strategies; factors influencing health policy; current state, federal and international health policy issues; political influence and the media; and policy-making frameworks and analysis. For more information contact Dr. Stephanie Ferguson, Program Director at (703) 993-1920, email: sfergus1@gmu.edu. The web site is http://chpre.gmu.edu.

The 9th Annual American Nursing Informatics Association Conference

The American Nursing Informatics Association presents
"Nursing Informatics: Beyond The Buzzwords"

WHEN: April 20-21, 2002 in San Diego, CA. For more information: www.ania.org

PUBLICATION KUDOS

Congratulations to **LTC William Gills**, Chief Nurse Anesthetist at Winn Army Community Hospital, Ft. Stewart, for his recent publication in Military Medicine, Vol. 166, November 2001, Orotrachial Intubation in Darkness Using Night Vision Goggles.

"Ready, Caring and Proud Giclée Painting"
by Artist Richard John Rezac

Editions and Pricing for painting by artist, Mr. Rezac.
#ANC-0001 "Ready, Caring & Proud" 100th Anniversary Commemoration

--36"x 24" Giclée Painting on Artist Canvas /Limited Multiple Original Edition of #75 plus #5 Artist Proofs.
Artist Proof (5) $ 1,000.00 + SH _____
Limited Edition (75) $ 750.00 + SH _____
Framing of Giclée Paintings $ 500.00 _____

--25"x 19" Offset Litho Art Print on 100# Gloss Text Stock in an Open Edition.

To Order the Giclée Painting, contact:

Richard Rezac Design, Inc.
26 Maple Cove Lane
Lampe, MO 65681
tel: (417) 779 5391/5392
e-mail: Studio@militaryartwork.com>
Web Url: http://militaryartwork.com